WISCONSIN MEDICAID
PRIOR AUTHORIZATION / BRAND MEDICALLY NECESSARY ATTACHMENT (PA/BMNA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case.

Prescribers are required to complete and sign the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA) and send it to the dispensing provider where the prescription will be filled. Dispensing providers are required to attach the completed PA/BMNA to a Prior Authorization Request Form (PA/RF) and a copy of the prescription and send the forms to Wisconsin Medicaid. Prescribers and dispensing providers are required to retain a completed copy of the form.

Dispensing providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Dispensing providers who wish to submit PA requests by mail may submit them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Enter the drug name.

Element 5 — Strength(s)
Enter the strength(s) of the drug listed in Element 4.

Element 6 — National Drug Code
Enter the appropriate 11-digit National Drug Code (NDC).

Element 7 — Date Prescription Written
Enter the date the prescription was written.

Element 8 — Directions for Use
Enter the directions for use of the drug.

Element 9 — Start Date Requested
Enter the start date requested for PA.

Element 10 — Diagnosis — Primary Code and / or Description
Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug or biologic requested. The ICD-9-CM diagnosis code must match the ICD-9-CM description.

Element 11 — Name — Prescriber
Enter the name of the prescriber.

Element 12 — Drug Enforcement Agency Number
Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

XX5555555 — Prescriber's DEA number cannot be obtained.
XX9999991 — Prescriber does not have a DEA number.

These default codes must *not* be used for prescriptions for controlled substances.

Element 13 — Address — Prescriber
Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code.

Element 14 — Telephone Number — Prescriber
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

Element 15
Indicate if "Brand Medically Necessary" is handwritten by the prescriber on the prescription order.

SECTION III — CLINICAL INFORMATION

Include diagnostic and clinical information explaining the need for the product requested. Documentation must indicate how the brand name drug will prevent recurrence of an adverse or allergic reaction, or a therapeutic failure, with the generic drug. In Elements 16 through 19, check "yes" to all that apply.

Element 16
Check the appropriate box to indicate if the recipient has experienced an adverse reaction to the generic drug. If yes, indicate the adverse reaction that can be directly attributable to the generic drug and the dates the drug(s) was taken.

Element 17
Check the appropriate box to indicate if the recipient has experienced an allergic reaction to the generic drug. If yes, indicate the allergic reaction.

Element 18
Check the appropriate box to indicate if the recipient has experienced an actual therapeutic failure of the generic drug. If yes, indicate the actual therapeutic failure.

Element 19 — For the following drugs only: Clozaril, Coumadin, Dilantin, Neoral, or Tegretol
Check the appropriate box to indicate if the recipient may experience an anticipated therapeutic failure. If yes, indicate the anticipated therapeutic failure and reaction.

Element 20 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 21 — Date Signed
Enter the month, day, and year the PA/BMNA was signed (in MM/DD/YYYY format).

SECTION IV — ADDITIONAL INFORMATION

Element 22
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.